The Scandinavian Psychoanalytic Review
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/rspr20

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Otto F. Kernberg [a]
[a] 21 Bloomingdale Road, White Plains , NY , 10605 , USA
Published online: 21 Jan 2013.

To cite this article: Otto F. Kernberg (1995) Omnipotence in the transference and in the countertransference, The Scandinavian Psychoanalytic Review, 18:1, 2-21, DOI: 10.1080/01062301.1995.10592328

To link to this article: http://dx.doi.org/10.1080/01062301.1995.10592328

Scand. Psychoanal. Rev. (1995) **18**, 2–21

THE
SCANDINAVIAN
PSYCHOANALYTIC
REVIEW
ISSN 0106-2301

Omnipotence in the transference and in the countertransference*

Otto F. Kernberg

The concept of omnipotence refers to a primitive fantasy, a mechanism of defense, and a pathological psychic structure. Omnipotence and its derivative defensive operation, omnipotent control, are highly prevalent in borderline personality organization. Three clinical vignettes illustrate these mechanisms in the treatment of patients with borderline, narcissistic, and obsessive personality disorders, respectively. These vignettes illustrate the transference developments when omnipotence and omnipotence control are dominant, and the therapeutic approach to these conditions.

GENETIC, DYNAMIC, AND STRUCTURAL FEATURES

Omnipotence was first described by Freud (1913, 1921) as a characteristic of infantile thinking and of the magic thinking of primitive cultures. He linked it with the state of primary narcissism and the hallucinatory satisfaction of desire under conditions of frustration. This primary mode of thinking might then reappear as a pathological mode of omnipotent thought in psychopathology, particularly in obsessive thinking. Within later developments, in both ego psychological and object-theoretical thinking, omnipotence was described as a defensive operation in the psychoses, one aspect of the permanence of magical thinking under conditions of loss of reality testing.

Thus, for example, Edith Jacobson (1967, 1971) described the omnipotent implications of psychotic identifications, in which refusion of self and object representations under conditions of idealized or ecstatic states

* An earlier version of this paper was presented at the New York Freudian Society on 11 October 1994.

recreates an omnipotence of thought that serves an important defensive function, together with denial of reality, thus preserving an idealized state as a defense against severe depression and even schizophrenic fragmentation.

Within the British schools, Melanie Klein's (1946) description of primitive defenses and object relations, linked to the early struggles between the life and death instincts, included omnipotence of thought as an early defensive operation. This defense, she proposed, was related to the defense against envy by means of an omnipotent fantasy of fusion between self and object that denied separation and dependence, and an omnipotent control of the object by means of projective identification. Herbert Rosenfeld's (1964, 1971) development of Klein's thinking stressed the behavioral aspects of omnipotent control as a major defensive operation in narcissistic personalities, thus shifting the emphasis from omnipotence of thought to omnipotent control as a crucial clinical manifestation of narcissistic pathology.

From a different viewpoint, Winnicott (1960a, b), describing the original undifferentiated structure of "baby and mother," focussed on the baby's sense of omnipotence when all his needs are met, in contrast to the sense of impingement when frustration of his desires faces him with the limits of his control of reality, and leads to the establishment of a transitional object in the road from primitive omnipotence to the acknowledgement of frustration and dependency.

As psychoanalytic exploration of severe character pathology, the borderline conditions, and the psychoses evolved in the hands of a broad spectrum of psychoanalytic theoreticians and clinicians (Jacobson, 1967; Mahler and Furer, 1968; Searles, 1965; Rosenfeld, 1987); the observations of the defensive functions of delusional grandiosity and omnipotence in schizophrenic, manic-depressive, and paranoid psychosis emerged in the literature of the 1950s and 1960s, and later on, the observations on the importance of omnipotent control in the psychoanalytic treatment of the borderline conditions and pathological narcissism.

The concept of omnipotence, therefore, refers to a primitive fantasy, a mechanism of defense, and a pathological psychic structure. These various aspects of omnipotence are present in many clinical situations that I shall attempt to outline from a genetic, dynamic, and structural point of view.

I propose that omnipotence as an early fantasy constitutes one aspect of the "all good" fused or undifferentiated self-object representation, related to what Freud (1930) originally described as the "oceanic feeling,"

and potentially reactivated, as an early defensive operation, whenever a regressive idealized fusional state emerges as a defense against the threat of frustration, trauma, pain and aggression. This original function of omnipotence as fantasy and defense is replicated, during the stage of separation-individuation (Mahler et al. 1975), in the fantasy of reunion between the "good self" and the "ideal object," the basis of both actual, secure dependency on a good object and a satisfactory relation of the ego to the early ego ideal. The pathological transformation of this development under conditions of manic and hypomanic states reflects the regressive refusion of these ideal relationships. The pathological construction involved in a pathological grandiose self (Kernberg, 1984) also implies the defensive aspect of omnipotence in a denial of all negative, split off and projected aspects of the self, denial of dependency on other objects, and fantasied undisturbed self gratification.

What I have described is the defensive utilization of early omnipotent fantasies in the segment of libidinal internalized object relations. A parallel process may be described regarding the development of aggressive object relations. Here, omnipotence evolves out of intense frustration, trauma, and pain as activators of aggressive affect and early defensive operations to deal with such affect that would include omnipotence and omnipotent control (Kernberg, 1992). In contrast to the function of omnipotence to assure an illusional pleasure and grandiosity in the libidinal segment, here, the aspect of control of the object becomes central, and omnipotent fantasies are now transformed into the defensive operation of omnipotent control.

Under pathological conditions, the aggressive drive dominates the early development of the psychic apparatus so powerfully that it leads to the psychopathological structures that we observe in psychosis, borderline personality organization, the severe types of perversion, and some psychosomatic disorders. This dominance of aggression has its roots in the excessive activation of aggressive affects. I have proposed in earlier work (1992) that affects are instinctive components of human behavior, that is, inborn dispositions that are common to all individuals of the human species; that they emerge in the earliest stages of development and are gradually organized, as part of early object relations, into gratifying, rewarding, pleasurable affects or libido as an overarching drive, and painful, aversive, negative affects that, in turn, are organized into aggression as an overarching drive. Within this conceptualization, affects are the inborn, constitutionally and genetically determined modes of reaction that are triggered

first by various physiological and bodily experiences, and then by the development of object relations from the beginning of life on.

Rage, within this conceptualization, represents the basic affect of aggression as a drive, and the vicissitudes of rage explain, in my view, the origin of hatred and envy, as well as anger and irritability as moods. Similarly, the affect of sexual excitement constitutes the core affect of libido, which slowly and gradually evolves out of the primitive affect of elation. Elation is produced by the infant's early sensual response to intimate bodily contact with mother. Thus, aggression as a drive develops out of the primitive crying response that evolves into the affect of rage first, and into the crying response as part of sadness, later. Hatred, the core affect of aggression as a drive is a later, structuralized aspect of rage, as is envy, a particular structural development of hatred.

The earliest function of rage is the effort to eliminate a source of irritation or pain. Rage is thus always secondary to frustration or pain, although the intensity of the rage response may depend upon temperamental features. A second function of rage is to eliminate an obstacle or barrier toward gratification. Here, the dynamics are more complex: an obstacle has to be eliminated to reach a fantasied or real source of gratification. This is the prototype for a third, higher developmental level function of rage, namely the elimination of a bad object, that is, a supposedly willful source of frustration standing between the self and the gratification of a need.

At a still more advanced developmental level, the wish is no longer to destroy the bad object, but to make it suffer: here, we are definitely in the complex developmental area in which pleasure and pain combine, sadism expresses a condensation of aggression and pleasure, and the original affect of rage appears transformed into hatred with new, stable structural characteristics. At a further level of development, the wish to make the bad object suffer shifts into the wish to dominate and control the bad object in order to avoid fears of persecution from it; now, obsessive mechanisms of control may psychopathologically regulate the suppression or repression of aggression. Finally, in sublimatory aspects of the aggressive response, the search for autonomy, self-affirmation, and freedom from external control reflect characteristics of the original, self-affirmative implications of rage.

Hatred, I propose, is a complex, structured derivative of the affect rage that expresses several wishes: to destroy a bad object, to make it suffer, and to control it. In contrast to the acute, transitory, and disruptive quality of rage, it is a chronic, stable, usually characterologically anchored or

structured affect. The object relationship framing this affect concretely expresses the desire to destroy or dominate the object. An almost unavoidable consequence of hatred is its justification as revenge against the frustrating object; the wish for revenge is typical of hatred. Paranoid fears of retaliation are also usually unavoidable accompaniments of intense hatred, so that paranoid features, a wish for revenge, and sadism go hand in hand.

One complication of hatred derives from the fact that very early frustration and gratification are experienced as stemming from the same source. Hence, the obstacle to gratification is the origin of that gratification, which brings us to the psychopathology of envy. I am referring to Klein's (1957) explanation of envy as a major manifestation of human aggression. Very early frustration, in Klein's terms, the absence of the good breast, is experienced by the baby as if the breast withheld itself, with an underlying projection into the breast of the baby's aggressive reaction to that frustration. The breast that aggressively withholds itself is, in turn, hated, and its fantasied contents are spoiled and destroyed. A vicious circle may ensue, in which the destroyed and destructive breast is experienced in a persecutory way, thus exaggerating and prolonging further the experience of frustration and rage. Here lies the origin of envy, the need to spoil and destroy the object that is also needed for survival, and, in the end, the object of love. The clinical study of patients with narcissistic personality disorder regularly reveals both unconscious and conscious envy as a major affective expression of aggression.

If we examine this progressive series of manifestations of the psychopathology of aggression, it becomes evident that a major transformation of the dominant affect of aggression evolves throughout this sequence. At the most primitive level of experience, the aggressive reaction centers around rage, and in the clinical situation, aggression of any level of development eventually leads to primitive rageful affect states in the transference. The crystallization of an external, bad object, in other words, the separation of self and object representation in the sector of aggression, transforms rage into hatred and the intimately related affect of envy. It is here where omnipotence emerges in the form of an effort at omnipotent control of the bad object.

I have suggested in an earlier work (1984) that projective identification may have an important early developmental function in fostering separation in the segment of primitive persecutory, "all bad" states, reflecting an effort to attribute the aggression to an external source, to maintain a purified idealized self and object-representation as a core self-experience,

and to protect the ideal segment of the self from the feared attack from the bad object. Clinically, projective identification (that is, the attribution of an internal impulse that cannot be tolerated by the object, maintenance of empathy with that dangerous, projected impulse, an unconscious tendency to induce the corresponding impulse in the object, and the need to control the object under the effect of the projected impulse), practically goes hand in hand with efforts at omnipotent control. We might also say that omnipotent control combines the fantasy of omnipotence with the aspect of control implied in the mechanism of projective identification. In short, omnipotent control evolves together with the psychopathology of hatred.

At still higher levels of development of the pathology of aggression, the complex affect of sadistic enjoyment of power replaces the dominance of primitive hatred. As I mentioned before, at this level, the wish is no longer to destroy the object but to make it suffer, or, in less primitive ways, to maintain it under one's own control. Here, omnipotent control becomes a powerful defense involved with the expression of sadistic power, and the maintenance of power as an essential precondition for the individual's psychological security. At a still more advanced stage of development, the internalization of sadistic or sadistically perceived objects as part of the oedipal level of superego structures, internalizes the conflict in the form of superego pressures, and secondary characterological identifications with the sadistic superego typical of obsessive compulsive personalities. Here the defensive operation of omnipotent control is transformed into the unconscious omnipotent fantasies of obsessive conditions.

In describing the typical constellation of primitive defensive mechanisms centering around splitting that characterize borderline personality organization (1975), I mentioned omnipotence and omnipotent control together with projective identification, primitive idealization, devaluation, denial, and splitting as characteristic defensive operations. From what I have described so far, the mutual relationships between omnipotence and omnipotent control, on the one hand, and all these other defensive operations, may become more apparent. To begin, both omnipotent fantasies and omnipotence as a defense in the libidinal sector, and omnipotent control in the aggressive sector, aim at protecting the splitting of idealized and persecutory segments of psychic experience. In the case of narcissistic personalities, omnipotence and omnipotent control protect the patient from dreaded separation, dependency, and envy, maintaining the idealized concept of the pathologic grandiose self.

I have already mentioned how projective identification and omnipotent control are indissolubly linked and reinforce each other under conditions of intense, primitive hatred, such as, for example, in patients who have experienced severe physical or sexual abuse. Omnipotence goes hand in hand with the operation of denial in manic and hypomanic conditions, and it is the counterpart of devaluation of significant others in schizoid, narcissistic, and hypomanic states. Primitive idealization of the self and omnipotence are also intimately linked. Thus, omnipotence and omnipotent control are essentially primitive defensive operations that are typically part of severe character pathology and psychosis.

CLINICAL MANIFESTATIONS AND TECHNICAL APPROACH

In my experience, the conditions in which omnipotence and omnipotent control appear most consistently in the transference are first, borderline personality organization, particularly the borderline, histrionic or infantile personality in a strict sense, the paranoid personality, and patients with severe sadomasochistic transferences in general; second, the narcissistic personality disorder, including the more severe forms of malignant narcissism; third, the obsessive personality disorder, particularly when the constituent identifications of the sadistic superego are enacted in the transference.

In what follows, I shall present three clinical vignettes that illustrate omnipotence and omnipotent control in these respective conditions.

(a) *Summary of a psychotherapy session with a patient presenting borderline personality organization, a narcissistic personality functioning on an overt borderline level, and in the middle of an extended enactment of sadomasochistic acting out in the transference.*

The patient, a college student in her early twenties, started the session asking me why I was not able to see her later the same day because this particular hour was very inconvenient. I told her that I had received her request through my secretary, and that I had left the message to her that I would not be able to see her later that day because of other commitments. The patient angrily interrupted me to say that she had mentioned some time ago that she wanted to see me at a later time on that day, if it were possible, and that I obviously had given preference to other patients regarding her hour. I pointed out to her that I realized that she felt that I was giving preference to other patients over her and she was angry because I was neglecting her and showing a preference for these other patients (this

patient had chronically experienced her mother as teasingly withholding love and interest from all the siblings in order to increase the rivalry among them).

The patient then asked me angrily to give her another time at the end of the same day, after I would have seen all the patients to whom I was committed. I said that she was having her session right now. She angrily insisted that this was a very bad time, that she was very angry, that she could not use her time under these conditions, and why could I not give her an additional time at the end of the day? I commented that her demand for an additional time (with the affirmation that this hour would be lost anyhow) indicated her wishes, on the surface, to punish me for not doing what she wanted, and at a deeper level, to punish me by destroying her own opportunity to experience me as somebody available to help her understand what was going on in this hour.

The patient interrupted me angrily to ask me why I wouldn't be able to see her at the end of the day, and what were my commitments in the evening that would prevent me from giving her another session. I pointed out that what I considered most important at this point was her perception of me as uninterested and neglectful, and her effort to transform me, by force if necessary, into a good therapist again by giving her an extra session.

The patient, even more angrily, said that the fact that I was neglectful and indifferent was obvious, that she understood that I was acknowledging this now, and that the least I could do under these conditions was to give her an additional session. At this point, she was ragefully insisting that I give her another session, practically interrupting me every time I tried to say something. I finally remained silent and she repeated the same accusations of my indifference, neglect, dishonesty, and provocative behavior again and again.

Eventually, I commented that she was repeating the same statements again and again, and what could be the function of that? Now the patient fell silent and looked at me with a hateful and depreciatory expression. After some silent minutes, I said that she was looking at me with a derogatory and hateful expression, and I wondered whether her silence now had the same function of her previous repetition of the same statements, namely to maintain an intensely adversary atmosphere in the session that would preclude our looking further into what was stimulating this rage.

The patient then said ironically, that if I wanted, I could go on saying whatever nonsense would come to my mind. I than said that her stream

of accusations against me reminded me of the way she had described her mother screamingly attacking her in her childhood, accusing her of all kinds of terrible behavior while the patient experienced herself to be the helpless victim of that assault, and that enacting this rôle of mother in relating to me gave her a sense of strength and power and that seemed more important to me than her efforts to obtain an additional session later the same day. (This was not a new interpretation; we had been exploring her tendency to enact the intensely aggressive relation with mother as torturer and she as victim, with frequent rôle reversals in the transference, throughout this entire period of her treatment.)

The patient remained silent, and after some minutes said that she was aware of what I was saying, but that I had provoked this situation. I pointed out to her that, if she really had not been able to come at this time, I would have evaluated whether we could find a better time to meet, but she had engineered the situation in a way that precluded such as solution. I also reminded her how often we had seen that she was an expert in provoking situations in which she would then feel that I had mistreated her. The patient then said that, in any case, while she was angry, she could still listen to what I was saying, and I wondered whether this meant that she really was experiencing what I was saying as thoughts that changed her view about herself, or whether she was now experiencing me as a powerful mother and she as the naughty little girl who had to make amends. She said she didn't feel she had to make any amends, and the hour ended shortly after, the patient leaving with a subtle smile.

(b) *A psychoanalytic session with a patient presenting a high-level narcissistic personality disorder.*

This patient, a businessman who consulted because of sexual promiscuity and severe marital problems had presented, in early stages of his treatment, a typical manifestation of omnipotent control in relating to my interpretations. He would listen to my interpretations very attentively, slowly repeating aspects of what I had said to him, musing about what I had said, and finally give his nod of approval. Whenever he felt that my interpretations were not at the level of his expectations, he would express his disappointment and disgust by telling me, half humorously, that I should work more intensely before making interpretations, or go back and review the basic texts of psychoanalysis, or else he would feel, quite despondently, that he had nothing to expect from me. At the same time, if what I was interpreting did not fit with his own view of the material, he would get anxious and question me: where did I get this interpretation from? what did it really mean?

He could not accept something that he himself had not thought before or could not immediately make his. This effort to control the analyst, to assure himself that the analyst was neither better than the patient (which would generate intolerance envy), nor worse than the patient (which would generate an intolerable devaluation of the analyst), had by now been worked through sufficiently in the transference, and the patient was beginning to establish a dependent relationship with me.

In recent months, this patient, for the first time in his life, had replicated his severe sadomasochistic relation with his mother in his childhood with a new girlfriend, the first extended relation he had after the termination of his marriage. At the same time, a subtle change occurred in the transference in the direction of its "emptying out". I sensed that the patient was so totally absorbed in the reality of his daily life with his girlfriend, that it was largely replacing his world of fantasy. I also felt that the patient seemed increasingly "unreal" in his behavior toward me. He became more and more "shadowy," and made me think of an "as if" personality at the time, as his conflict with his girlfriend became clearer.

Over a period of months, the contents of the sessions became increasingly invaded by the references to all the struggles with this girlfriend, complicated involvements in the struggles with her of members of her and his family, and an increasing chaos in his life situation, simultaneously with the development of what impressed me as robot-like behavior in the sessions. For example, in reaction to an interpretation, the patient would move backward on the couch into a half sitting position, support his chin in hand as if reflecting about what I had said. He brought typewritten pages with dreams that he wanted to read to me; when I asked why he felt the need to bring these typewritten dreams rather than talking freely in the hour, he offered the chagrined statement that he was only interested in accelerating the analytic work; with the resigned gesture he would then proceed to relate the dreams from memory.

The interpretation of his behavior was made more difficult by the subtlety of all these developments, which may here appear as clearer than they did in the sessions. Over a period of months, I had the feeling of carrying out an "as if" analysis, in the sense that my interpretations would become so clearly integrated in the patient's associative material that I could no longer assess their effect. When I communicated to him that I experienced an enormous distance in our relationship, the patient freely acknowledged that he felt independent from me, and that this must indicate that he was now much healthier than before.

His ongoing friendliness, his apparent attention to everything that I was saying, an apparent uninhibited flow of free associations only punctuated my feeling that our relationship was completely phony, and I felt strangely reluctant to confront the patient with my feeling, as if it would be hopeless to even try. I sensed that either he would not understand what I was saying and think I was being paranoid, or react in a helpless way, as if I were making impossible demands on him, while he was so obviously a "good" patient who was improving in his understanding and in his life.

In some sessions, he made me feel that the only thing that he needed to get better was for me to inculcate him with the capacity for tender love towards his girlfriend. In short, I felt controlled and paralyzed in an emotional experience of "phoniness," a sense of enormous emotional distance in our relationship, an alternative of either having him experience me as "crazy" if I persisted in confronting him with the robot-like aspects of his behavior, or of overwhelming him with demands for authenticity that he would not be able to comprehend.

Only gradually did I realize that my sense of impotence resulted from identifying with the patient in his relation to his "crazy" mother: I was submitting to the patient (mother) like a submissive son who was carrying out a pseudo-analysis as prescribed by mother. I thought that the patient was unconsciously identifying with his mother, pretending to be caring and treating me as a son who had to be manipulated into obedience. In my efforts to break out of this situation, I was tempted to act like an impatient, controlling mother who would pretend that she knew exactly what was going on in her child without listening to him, overpowering him and forcing him either to protest in rage or obligingly submit.

I am describing an atmosphere created by this patient throughout time, treating me with what, on the surface, seemed friendliness, a natural attitude, which yet had subtle and extremely controlling effects on me. What follows is a segment of a session in which I attempted to transform my countertransference reaction, that, on reflection, seemed to express my identification with the patient as an impotent child, into an interpretation of the dominant issues in the transference.

The session started with Mr. B saying that he had had an uncanny experience of proposing a major business deal to a firm connected with a foreign country, and that he had become afraid that this business deal would be resented by a competitor attempting to do a similar deal with still another country. The patient suddenly became afraid that agents working for his competitor in that other country might try to steal from

him the information about the specific technology involved. While telling me that he knew that this was a paranoid reaction, he was still afraid after leaving the office of the representatives of the foreign firm, and he thought that two men were following him that afternoon and late into the evening. He said he had become very anxious and was oscillating between a sense that this was exaggerated and a feeling that it might be true and that he should watch out. The patient felt genuinely anxious in conveying this information to me.

At the same time, as was frequent in recent months, the patient would turn toward me, from time to time, smiling, as if saying, "I know this is crazy, and I know you understand that I understand." I said that I realized that he was oscillating between fear and a sense that the fear was absurd, and that he was looking at me as if to reassure me that he was aware of that, but perhaps also to reassure himself whether I was still on his side or whether I was silently concluding that he was crazy. The patient immediately said that he didn't think that I would think that he was crazy, and smiled at me with the reassuring expression on his face. I told him that I felt he was giving me a reassuring smile as if some danger had to be avoided in this situation, and the patient remarked jokingly that the only danger could be that I might be aligned with the foreign country with whom his competitor was colluding. I now realized that the patient had not told me which country that was, and I mentioned that to him as a further indication of his fearfulness of me. My fantasy was that the foreign competitor was my country of origin, but I did not communicate this to the patient. He then became clearly uneasy, and reluctantly commented that the thought had crossed his mind whether my office was wired, and whether it wouldn't be easy for me to obtain confidential information from him that I could use for my own purposes. He went on to associating about the possibility of break-ins into psychiatrists' offices, linked it with the Watergate affair and several films in which psychiastrists had been involved in shady, dangerous deals. I pointed to his efforts to defend himself against a vision of me of dangerously spying on him by projecting the enemies as foreign agents rather than I myself being a foreign agent operating against him.

Mr. B, again smiling, and somewhat ironically, thought that I might need more protection for myself rather than being dangerous, and remembered an incident in which what he considered (realistically) to be a psychotic woman had appeared in my waiting room attempting to enter the office before him. On that occasion, he had become intensely fearful that

she might reappear later in the session with a gun, and, in attempting to shoot me, would shoot him. He said, half jokingly, "that woman might reappear any day and stab you in the back." I said I wondered whether he was trying to make a joke out of a fantasy that otherwise might be very frightening to him, namely, that I might stab him in the back by betraying his technical innovations to a competitor.

As I was saying this, I had two contradictory feelings: that I was on the right patch in interpreting his "phony" friendliness as a defensive omnipotent control against an underlying paranoid relationship in the transference, and, at the same time, I experienced myself as forcefully invading the patient with interpretations beyond his capacity for immediate awareness, "brain-washing" him, as it were, enacting a paranoid mother. For some fleeting moments, I felt really "paranoid" in interpreting a primitive persecutive fantasy to this smiling, relaxed patient. But then I felt that my fantasy reflected my fear to assert myself as a father who could transcend this madness, and transform what seemed a "violent" interpretation into a "reasonable" one.

Mr. B remained silent and suddenly appeared very tense. I told him that he looked very tense all of a sudden. He said he had just had the image of himself stabbing his mother. He then remained silent but looked extremely tense. He then said he was very upset, and he would never do such a thing. I told him I thought he was trying to reassure me and himself that he would never stab his mother, afraid that his wishes to stab her might be the same thing as actually stabbing her. I also wondered whether his fear and his wish to stab his mother might be connected with his fear of my stabbing him in the back: I interpreted his projecting his own rage onto me and I said that I wouldn't be surprised if his immediate response would include some effort to transform this into a humorous situation in order to take the edge off the frightening feeling that we were exploring.

The patient then said that he wasn't surprised that I should say that, but that he had been thinking very seriously of how enraged he had become at his mother in the last extended telephone conversation, and he proceeded to talk with great emotion about an aspect of her discourse that seemed to him totally crazy and that he felt impotant to puncture. I then said that I wondered whether he had been putting his sense of impotence in dealing with the crazy mother into me while enacting the rôle of the crazy mother himself in the session, but conveying to me his crazy behavior, telling me that he knew it was crazy, and yet enacting it in his watchful turning around to observe me, while I, attempting to show him the serious aspects of what was

going on beyond the nicety of his friendly smile and his comments, might have been easily derailed by these very niceties, or appear to be crazy by pointing to the madness going on in fantasy in this room, namely the danger that I might stab him like an impotent enraged boy would stab a crazy dominant mother. A lengthy silence followed. The patient said that it was true that he tried to always keep things on an even keel with me, and in fact, that had been his usual behavior with all women, except now with his new girlfriend; and that he realized how enraged he was at all women. And that was the end of the session.

(c) *A psychoanalytic session with a patient presenting an obsessive personality.*

This patient, a businessman in his mid-thirties, had consulted because his obsessive doubts interfered severely with his business decisions, chronic anxiety, depression, and sexual inhibition in the relationship with his wife. He also would get easily involved in power struggles with business associates and clients that had been damaging to his business enterprise.

The following session occurred in the third year of his psychoanalysis. The last session before a week-long separation during which the patient had a commitment out of town that coincided with my own absence, started with the patient's obsessively discussing whether he should give in to the financial demands of a provider whose product he wanted to acquire or whether he should stand firm on his counterproposal. Gradually, his anger at the provider became stronger. He complained bitterly about the lack of gratitude of this young man whom the patient had helped in the past, and expressed indignation at the defiant and inconsiderate ways in which the man was treating him. I raised the question whether, in the middle of this disappointment, there might also be disappointment with me for not helping him to make a decision. My patient responded with irritation that I was wrong; he wasn't expecting anything from me, and this analysis was proving to be completely useless.

I wondered aloud whether his disappointment with me might have something to do with the forthcoming week-long separation. I reminded him that I had wondered whether he had set up a business trip at the time of my absence in order to avoid a feeling of being left behind and left alone. He responded that, to the contrary, he would have to cancel an additional hour at the time of his return because of flight complications. At that moment, I remembered that I had a similar flight problem, and told the patient that I had planned to suggest to him a session at a later time on the day of our first appointment.

The patient then really became enraged at me. Why was I bringing up a change in his schedule in the middle of a session, when my usual practice was to convey new information of any kind to him only at the beginning of a session? I was disrupting his flow of free association, he went on, showing how distracted I was by raising issues that concerned only me, and was totally neglectful of his needs. This was the last thing he would have expected at the last session before the one week separation!

The patient's anger increased. In the next few minutes, I experienced the rapidly changing set of feelings. First, I felt guilty for not having remembered to make my suggestion at the beginning of the session, feeling that I had indeed been neglectful, and wondered what might have influenced me in this regard. I remembered that I had a fleeting sense of guilt before the session for having to make a last-minute change in the patient's schedule, and wondered to myself whether I was acting like my patient's mother (that is, pretending to be interested and concerned for him). Then, as his attacks on me intensified, I became irritated, feeling that he was making a mountain out of a relatively minor molehill. I thought that I had fairly acknowledged my mistake. Finally, while the patient continued to express his rage over my unreliability, I thought that I was now in the relationship to him similar to the one he had experienced when confronted with this father's dissatisfaction with his performance. The patient was now enacting the rôle of his father and projecting his "unreliable self" onto me, replicating, at the same time, his problem in relationship to the young provider.

I commented on his disappointment and its transformation into rage at me, his sense that I was unreliable because I was not helping him with his problem with the young provider, and because I was neglecting the particular intensity of his need to be understood and cared for when a separation brought about the feeling of being abandoned. I interpreted that I was like an unreliable mother who only pretended to care for him, a most painful experience against which he could protect himself by changing it into making me an unreliable son and enacting his father's demands in relation with me. To be an angry father scolding an unreliable son was preferable to feeling like an abandoned son relating to an unreliable mother.

The patient said that he had felt that the provider was like an unreliable, unloving son, and that it was true that he had been treating both that provider and me in ways that remained him of what he hated in his father. And then he added that he did not feel as fearful as he had in the past

about some forthcoming important meetings, that he felt more like an equal with his colleagues. He then remained silent. After a while, I commented that I sensed a change in his emotional disposition. He said he was no longer angry and actually felt sad thinking of our separation for a week. I said that, insofar as it was less frightening to him to identify himself with his father in spite of father's traits that he was so critical of, he was also less afraid to acknowledge his wishes for my concern and dedication to him, without experiencing that as a sexual threat. The patient then remembered that he had felt less inhibited in having sex with his wife the previous night. The session ended shortly afterward.

I need to stress that this patient's unhappiness and rage with my bringing in the subject of my need to delay his first session after his return represented a relatively weak manifestation of his need, during earlier stages of his analysis, to have me behave in an exact, consistent, and predictable way to the last detail of our interactions, in fact treating me with an attitude of omnipotent control that reflected both the unconscious identification with his father and the enactment of his own internalized sadistic superego. The fact that this aspect of his pathology was already being worked through over an extended period of time shows in the relative ease with which my interpretation helped to resolve this defensive operation and shift the emotional reaction in the transference. In general, however, the analysis of omnipotent control in the transference of obsessive personalities is easier to accomplish in less time than what is usually necessary in cases of severe psychopathology reflected in the two earlier examples.

SOME FURTHER CONSIDERATIONS REGARDING TECHNIQUE

The activation of omnipotence as a defensive operation in the transference usually takes the form of omnipotent control. The uncovering of unconscious omnipotence as part of an obsessive personality structure, in schizoid personalities and other personality disorders, is much less of a technical problem than the enactment of omnipotent control, usually in the context of the simultaneous activation of several of the entire constellation of primitive defensive operations. The activation of advanced defensive operations accompanying omnipotent control in the case of obsessive personalities is less of a problem: usually intellectualization, rationalization, and reaction-formations are defenses presenting together with omnipotent control in the case of neurotic personality organization. In contrast, the

most extreme cases of omnipotent fantasies and enactment in psychotic conditions are in theory the most difficult to approach with a psychoanalytic perspective, and are part of highly specialized indications and techniques of psychoanalytic psychotherapy with psychotic patients.

For practical purposes, then, management of omnipotent control in several personality disorders represents the most frequent clinical situation we have to deal with. The main problem under conditions of enactment of this defensive operation is how to maintain a position of technical neutrality without being manipulated into a position of rigidity that lends itself to an enactment of projective counteridentification, that is, a countertransference identification with the same tendency toward omnipotent control that the patient is trying to avoid recognizing in himself. Obviously, an alternative danger is to give in to the patient's action, and shift the nature of the relationship in accordance with the patient's pressure and demands. The therapist's masochistic submission to a patient's enactment of sadistic control may, temporarily, appear to improve the therapeutic relationship and reduce the expression of overt aggression in the transference, but at the cost of driving the corresponding conflict underground or leading to the splitting off of the negative transference from a protective idealization of the therapist related to the acting out of omnipotent control in the transference. Thus, for example, if I had agreed to my first patient's demand that I give her an additional appointment late that evening, she would have probably relaxed immediately, become very friendly, shifted into telling me about new developments in her daily life, but the underlying identification with her sadistic mother would no longer have been emotionally available for analytic work at that time.

In my experience, it is practically unavoidable that, in response to the expression of omnipotent control in the transference, the therapist will be forced to reassess and reassure the boundaries of the psychoanalytic relationship, in other words, reaffirm the overall treatment frame, and, under conditions of severe and potentially dangerous acting out in the transference, set limits to protect the treatment and the patient. Clear boundaries of the treatment situation, a clearly established understanding of time limits, consistent limits to protect the patient, the therapist, and the space where they work together from destructive aggression, also protect the therapist from countertransference acting out and provide the space for the therapist's countertransference analysis as a preliminary step to continue the transference interpretation at that point.

I refrained from mentioning countertransference development in the

first example that I gave because, being alert through many similar previous experiences to the patient's angry outbursts when her demands were not met, my internal sense of clarity and security regarding the limits to which acting out in the sessions could be expressed, permitted me to maintain a relative equanimity in the face of her angry onslaughts. In contrast, in the second example, the enormous difficulty in resolving the patient's massive combination of omnipotent control and denial in the transference was affecting my countertransference disposition and required significant work outside the treatment hours before I became able to interpret that defensive operation in the way I illustrated in that example.

In my experience, from the viewpoint of interpretive management of omnipotent control, the most difficult cases are represented by severely traumatized borderline patients who enact a victim-victimizer dyad in the therapeutic interaction, with an intensity and rapidity of rôle reversals that create a maximum risk for intense countertransference developments and countertransference acting out that may contribute to maintaining vicious circles of transference acting out.

In conclusion, in the treatment of patients whose transferences are dominated by hatred, it is important, first of all, to establish a rigorous, flexible, yet firm frame for the therapeutic relationhip; this step controls life-threatening and treatment-threatening acting out. The therapist has to experience himself as safe to be able to analyze the deep regression in the transference. What must be especially guarded against in the treatment of victims of abuse in the tendency to avoid the analysis of the patient's identification with the aggressor. To treat the patient consistently as victim facilitates the projection of the aggressor rôle outside the transference, which perpetuates an idealized transference situation dissociated from the basic dyad controlled by hatred, thus perpetuating the patient's psychopathology. To treat the patient as a responsible adult rather than a perennial victim includes the painful need for the patient to become aware of how, in reaction to the trauma, he/she identified with the persecutor.

The combination of intense hatred, omnipotent control, and projective identification in the transference, and of the need to establish and maintain firm boundaries of the treatment situation in order to continue an analytic approach, will often make it almost impossible, in the short run, to differentiate the therapist's firmness, technical neutrality, holding and containing patterns from acting out of omnipotent control in a projective counteridentification, that is, in the countertransference. Such a difficulty in clarification of this situation in the short run may feed into the therapist's

masochistic potential and lead to a dangerous, guilt-motivated submission to the patient's acting out, eventually followed by an internal or actual rejection of the patient.

In contrast, tolerance of this ambiguity on the part of the therapist while he or she maintains an ongoing analysis of transference and countertransference outside as well as during the sessions under such trying conditions, usually permits clarification of the patient's transference, and facilitates the analyst's consistent capacity to absorb the aggression without reacting with counteraggression, abandonment of the patient, or masochistic surrender. The analyst's consistency and firmness, in turn, will permit the patient to gradually realize that his aggression is not as dangerous and intolerable as he feared. In identifying with the observing function of his therapist, the patient may thus develop the potential for accepting and elaborating his own aggression, and reduce the splitting mechanisms separating idealized and persecutory internalized object relationships, all of which leads to the integration of self- and object-representations, the tolerance of ambivalence, and the deepening and maturing of internalized and actual object relationships.

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Otto F. Kernberg
21 Bloomingdale Road
White Plains, NY 10605
USA